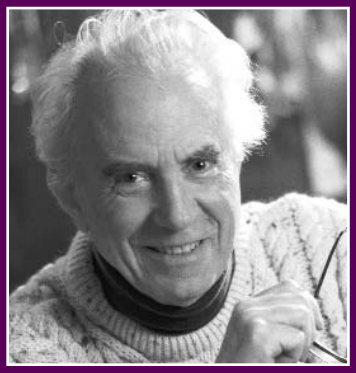
Choosing A Medigap Policy



2003 Guide To Health Insurance For People With Medicare

For People in the Original Medicare Plan

This Guide has easy steps to help you buy Medicare Supplement Insurance.

Developed by the Centers for Medicare & Medicaid Services (CMS) jointly with the National Association of Insurance Commissioners

Welcome to the 2003 Guide To Health Insurance For People With Medicare: Choosing A Medigap Policy

How This Guide Can Help You

This Guide is about "Medicare Supplement Insurance," also called "Medigap Policies." A Medigap policy is a health insurance policy sold by private insurance companies to help you pay some of the medical costs the Original Medicare Plan (fee-for-service) doesn't cover. Choosing a Medigap policy is a very important decision.

This Guide provides you with valuable information and helps you understand:

- What Medigap policies are,
- How Medigap policies can help you,
- What to do before you buy a Medigap policy, and
- How to choose the best Medigap policy for you.

Only you can decide if you need a Medigap policy with the Original Medicare Plan. This Guide can help you!

Remember, there are many things to think about before you make a decision. There are other kinds of health coverage, besides a Medigap policy, that may pay for some of your health care costs not covered by Medicare (see page 58).

You don't need a Medigap policy if you are in a Medicare + Choice Plan.

The *2003 Guide To Health Insurance For People With Medicare: Choosing A Medigap Policy* is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

The information in this Guide was correct when it was printed. Changes may occur after printing. For the most up-to-date version, look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

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Notes

Section 1: A Quick Look At Medicare

"We weren't sure what Medicare covered until we read over this section."

Medicare has two parts:

- Part A Hospital Insurance, see page 5. Most people don't have to pay for Part A.
- Part B Medical Insurance, see pages 5-8. Most people pay monthly for Part B.

Medicare Health Plan Choices

Depending on where you live, you may be able to get your health care coverage in several ways. Medicare offers the following types of Medicare health plans:

Medigap policies only help pay health care costs if you are in the Original Medicare Plan.

The Original Medicare Plan - The Original Medicare Plan is a "fee-for-service" plan. You are charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. You will stay in the Original Medicare Plan unless you choose to join a Medicare + Choice Plan. Many people in the Original Medicare Plan also buy a Medigap **(Medicare Supplement Insurance)** policy to help pay health care costs that this plan doesn't cover.

Medicare + Choice Plans (pronounced "Medicare plus Choice") - Medicare + Choice Plans provide care under contract to Medicare. There are two types of Medicare + Choice Plans. They are available in many parts of the country.

Medicare + Choice Plans include the following:

- **Medicare Managed Care Plans** (like HMOs and PPOs), and
- **Medicare Private Fee-for-Service Plans**.

Important: If you belong to a Medicare + Choice Plan, the plan must cover at least the same benefits as Medicare Part A and Part B. However, your costs may be different, and you may have extra benefits, like coverage for prescription drugs or additional days in the hospital.

It is important to know how you get your Medicare health care. To learn more about Medicare, look at your copy of the *Medicare & You* handbook (CMS Pub. No. 10050), which is mailed each fall to people with Medicare. You can order a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also read or print a copy of this handbook at www.medicare.gov on the web. Select "Publications."

Words in purple are defined on pages 82-85.

Medicare Part A

Medicare Part A (Hospital Insurance) helps pay for the following:

- Inpatient hospital care,
- Skilled nursing facility care,
- Hospice care, and
- Some home health care.

For more information on what Medicare Part A covers, see the coverage chart on page 69.

How To Get Medicare Part A

If you are already getting Social Security or Railroad Retirement benefits you will get Medicare Part A automatically when you turn age 65. If you are close to age 65 and are not yet getting Social Security or Railroad Retirement benefits or Medicare Part A, you can apply for both at the same time. You can also apply for Medicare Part A only. You will not pay a monthly payment called a premium for Medicare Part A because you or your spouse paid Medicare taxes while working. This is called premium-free Medicare Part A.

For more information on what Medicare Part B covers, see the coverage charts on pages 70-72.

If you (or your spouse) didn't pay Medicare taxes while you worked, and you are age 65 or older, you still may be able to buy Medicare Part A. If you aren't sure if you have Medicare Part A, look on your red, white, and blue Medicare card. It will show "Hospital (Part A)" on the lower left corner of the card. You can also call the Social Security Administration at 1-800-772-1213 or call your local Social Security office for more information about buying Medicare Part A. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Medicare Part B

Medicare Part B (Medical Insurance) helps pay for the following:

- Doctors' services,
- Outpatient hospital care, and
- Some other medical services that Medicare Part A doesn't cover (like some home health care including durable medical equipment).

Medicare Part B helps pay for these covered services and supplies when they are medically necessary.

How To Get Medicare Part B

You are automatically eligible for Medicare Part B if:

- You are eligible for premium-free Medicare Part A, or
- You are a United States citizen or permanent resident age 65 or older.

Just before you turn 65 years old, you have to decide whether or not to enroll in Medicare Part B. If you are already getting Social Security benefits, Medicare will enroll you in Medicare Part B automatically. You should keep in mind that the cost of Medicare Part B will go up 10% for each 12-month period that you could have had Medicare Part B but didn't sign up for it, except in special cases (see pages 7-8, "The Special Enrollment Period For Medicare Part B").

If you choose to enroll in Medicare Part B, you pay the Medicare Part B premium of $58.70 per month (in 2003). Rates can change every year. For some people, this amount may be higher if they didn't choose Medicare Part B when they first became eligible at age 65.

The premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. In these cases, you **won't** get a bill for your premium. If you don't get any of these payments, Medicare sends you a bill for your Medicare Part B premium every three months. If you don't get your bill by the 10th of the month, call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

If you didn't sign up for Medicare Part B when you were first eligible, you may sign up during two enrollment periods:

- The General Enrollment Period, see page 7, and
- The Special Enrollment Period, see pages 7-8.

The General Enrollment Period For Medicare Part B

This period runs from January 1 through March 31 of each year. During this time, you can sign up for Medicare Part B at your local Social Security office. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772. Your Medicare Part B coverage will start on July 1 of the year you sign up. Remember, the cost of Medicare Part B will go up 10% for each 12-month period that you could have had Medicare Part B but didn't take it, except in special cases (see below). You will have to pay this extra amount for as long as you have Medicare Part B.

The Special Enrollment Period For Medicare Part B

This period is available if you waited to enroll in Medicare Part B because you or your spouse were working **and** had group health coverage through an employer or union based on this current employment. Most people who sign up for Medicare Part B during a Special Enrollment Period don't pay higher premiums.

If this applies to you, you can sign up for Medicare Part B:

- Any time you are still covered by an employer or union group health plan, through your or your spouse's current or active employment, or
- During the eight months following the month that the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

Note: If you are still working and plan to keep your employer's group health coverage, you should talk to your benefits administrator to help you decide when is the best time to enroll in Medicare Part B. **When you sign up for Medicare Part B, you automatically begin your Medigap open enrollment period**. Once your Medigap open enrollment period begins, it cannot be changed or restarted. See pages 18-20 to learn more about your Medigap open enrollment period.

The Special Enrollment Period For Medicare Part B (continued)

If you are disabled and working (or you have coverage from a working family member), the Medicare Part B Special Enrollment Period rules may also apply.

Remember, most people who sign up for Medicare Part B during a Special Enrollment Period don't pay higher premiums. **However, if you are eligible but don't sign up for Medicare Part B during the Special Enrollment Period, you will only be able to sign up during the General Enrollment Period (see page 7), and the cost of Medicare Part B may go up.**

For more information about signing up for Medicare Part A and Part B, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

If you have End-Stage Renal Disease (ESRD), different rules for enrollment may apply. For more information about ESRD, get a free copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* (CMS Pub. No. 10128). Look at www.medicare.gov on the web. Select "Publications." Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 2: Medigap Policy Basics

"This section gave me the basic information I needed to know to buy a Medigap policy."

What Is A Medigap Policy?

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, different types of standardized Medigap plans are sold in your state. For more information, see pages 73-75.

A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage.

There are ten standardized Medigap plans called "A" through "J." The front of a Medigap policy must clearly identify it as "Medicare Supplement Insurance." **Each plan A through J has a different set of benefits**. Plan A covers only the basic (core) benefits (listed on page 14). These basic benefits are included in all the Plans, A through J. Plan J offers the most benefits.

When you buy a Medigap policy, you pay a **premium** to the insurance company. This premium is different than the Medicare Part B premium you must also pay. As long as you pay your premium, your policy is **guaranteed renewable**, which means it is automatically renewed each year. Your coverage will continue year after year as long as you pay your premium. If you buy a Medigap policy, it only covers your health care costs. It doesn't cover any health care costs for your spouse.

Important: In some states, insurance companies may refuse to renew a Medigap policy bought before 1990. At the time these policies were sold, state law was not required to say the Medigap policies had to be renewed automatically each year.

Medigap policies only help pay health care costs if you have the Original Medicare Plan. You don't need to buy a Medigap policy if you are in a Medicare + Choice Plan. In fact, it is illegal for anyone to sell you a Medigap policy if they know you are in one of these plans.

It is also illegal for an insurance company to sell you a Medigap policy if you have Medicaid except in certain situations (see page 60).

What Is Not A Medigap Policy?

A Medigap policy is not:

- Coverage you get from your employer or union,
- A Medicare + Choice Plan,
- Medicare Part B, and
- Medicaid.

Who Can Buy A Medigap Policy?

To buy a Medigap policy, you generally must have Medicare Part A and Part B. If you are under age 65 and you are disabled or have End-Stage Renal Disease (ESRD), you may not be able to buy a Medigap policy until you turn 65.

More information about Medigap policies for people under age 65 starts on page 38.

Can I Keep Seeing The Same Doctor If I Buy A Medigap Policy?

In most cases, yes. If you are in the Original Medicare Plan and you have a Medigap policy, you can go to any doctor, hospital, or other health care provider who accepts Medicare. However, if you have the type of Medigap policy called Medicare SELECT, you must use specific hospitals and, in some cases, specific doctors to get your full insurance benefits.

What Is Medicare SELECT?

Medicare SELECT is a type of Medigap policy available in some states. If you buy a Medicare SELECT policy, you are buying one of the ten standardized Medigap plans A through J. With a Medicare SELECT policy, you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits (except in an emergency). For this reason, **Medicare SELECT policies generally cost less than other Medigap policies**.

Words in purple are defined on pages 82-85.

Why Would I Want To Buy A Medigap Policy?

You may want to buy a Medigap policy because Medicare doesn't pay for all of your health care. There are "gaps" or costs that you must pay in the Original Medicare Plan. The chart on page 13 gives some examples of these gaps. Remember, no Medigap policy will cover all the gaps in the Original Medicare Plan.

If you are in the Original Medicare Plan, a Medigap policy may help you:

- Lower your out-of-pocket costs, and
- Get more health insurance coverage.

What you pay out-of-pocket in the Original Medicare Plan will depend on the following:

- Whether your doctor or supplier accepts "assignment" which means takes Medicare's approved amount as payment in full,
- How often you need health care,
- What type of health care you need,
- Whether you buy a Medigap policy,
- Which Medigap policy you buy, and
- Whether you have other health insurance.

You don't need a Medigap policy if you are in a Medicare + Choice Plan.

Some examples of Gaps in Medicare covered services What YOU Pay in 2003		A Medigap Policy May Help Pay These Costs
Hospital Stays	• $840 for the first 60 days • $210 per day for days 61-90 • $420 per day for days 91-150	✓
Skilled Nursing Facility Stays	• Up to $105 per day for days 21-100	✓
Blood	• Cost of the first 3 pints	✓
Medicare Part B yearly deductible	• $100 per year	✓
Medicare Part B covered services	• 20% of Medicare-approved amount for most covered services • 50% of the Medicare-approved amount for outpatient mental health treatment* • Copayment for outpatient hospital services	✓

* All Medigap policies must pay 50% coinsurance for outpatient mental health treatment services.

Note: Some Medigap policies also cover other extra benefits that aren't covered by Medicare. Some examples of these benefits include the following:

- Routine yearly check-ups,
- At-home recovery,
- Medicare Part B excess charges (the difference between your doctor's charge and Medicare's approved amount). The excess charge only applies if your doctor doesn't accept assignment,
- Prescription drugs,
- And more (see page 15).

What Medigap Policies Don't Cover

- Long-term care,
- Vision or dental care,
- Hearing aids,
- Private-duty nursing, or
- Unlimited prescription drugs.

What Medigap Policies Cover

Each standardized Medigap policy must cover basic (core) benefits (see below). Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance and outpatient copayment amounts. These policies may also cover Original Medicare Plan deductibles. Some Medigap policies cover extra benefits to help pay for things Medicare doesn't cover (see page 15).

Medigap Plans A through J Basic (Core) Benefits Include:

- The Medicare Part A coinsurance amount for days 61-90 ($210 per day in 2003), and days 91-150 ($420 per day in 2003) of a hospital stay,
- Coverage of up to 365 more days of a hospital stay during your lifetime after you use up all Medicare hospital benefits,
- The coinsurance or copayment amount for Medicare Part B services after you meet the $100 yearly deductible (in 2003), and
- The first three pints of blood or equal amounts of packed red blood cells per calendar year, unless this blood is replaced.

See page 15 for more information about Medigap plans A through J.

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 73-75.

Your Medigap Plan Choices - Medigap Plans A Through J

Medigap policies (including Medicare SELECT) can only be sold in ten standardized plans. This chart gives you a quick look at all the Medigap plans and their benefits. Read down to find out what benefits are in each plan. If you need more information, call your State Insurance Department (see pages 79-80.)

A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible
		Medicare Part B Deductible			Medicare Part B Deductible				Medicare Part B Deductible
					Medicare Part B Excess Charge (100%)	Medicare Part B Excess Charge (80%)		Medicare Part B Excess Charge (100%)	Medicare Part B Excess Charge (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drug Benefit ($1,250 Limit)	Basic Drug Benefit ($1,250 Limit)	Extended Drug Benefit ($3,000 Limit)
				Preventive Care					Preventive Care

* Plans F and J also have a high deductible option (see page 17).

Important Notes

- All Medigap plans must cover the basic benefits listed on **page 14**.
- For details about the Medigap plan extra benefits listed in the chart (Skilled Nursing Coinsurance, Medicare Part A and Part B Deductible, Medicare Part B Excess Charge, Foreign Travel Emergency, At-Home Recovery, Prescription Drugs, and Preventive Care), see **pages 24-25**.
- This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin, see **pages 73-75**.

Chart

How Much Do Medigap Policies Cost?

The cost of Medigap policies varies widely. The cost can vary by:

- Your age,
- Where you live, and
- The insurance company.

Insurance companies have three different ways of pricing policies. For details about these three ways, see pages 34-35. Although this Guide **can't** provide actual costs of Medigap policies, there is some information about Medigap costs in the Medicare Personal Plan Finder at www.medicare.gov on the web. This tool is described in detail on page 40.

There can be big differences in the premiums that insurance companies charge for exactly the same coverage. As you shop for a Medigap policy, you will need to call insurance companies that sell Medigap policies in your state and ask about prices. When you compare premiums, be sure you are comparing the same Medigap policies.

Other Factors That May Affect Your Cost

- **Whether you are male or female**.
  Some companies offer discounts for females.
- **Whether you smoke.**
  Some companies offer discounts for non-smokers.
- **Whether you are married.**
  Some companies offer discounts for married couples.
- **Whether the insurance company uses medical underwriting.**
  This is a process that an insurance company uses to review your health and medical history, and decide whether to accept your application for insurance, how much to charge you and whether to make you wait for some benefits.

  With medical underwriting, you usually must answer medical questions on an application. You need to fill out this application carefully and completely or your policy could be invalid. Some companies may want to review your medical record before they sell you a policy. The company can use this information to decide how much to charge you for a Medigap policy and to add a waiting period for pre-existing conditions if your state law allows (see page 36).

Other Factors That May Affect Your Cost (continued)

- **Whether the insurance company uses medical underwriting. (continued)**
  Insurance companies may "medically underwrite" any Medigap policy unless you are in your Medigap open enrollment period (see page 18) or you have special rights to buy a Medigap policy (see page 41).

- **Whether you buy a High Deductible Option Policy.**
  Insurance companies may offer a "high deductible option" on Medigap Plans F and J (see chart on page 15). If you choose this option, you must pay a $1,650 deductible for the year 2003 before the policy pays anything. This amount can go up each year.

  High deductible option policies often cost less, but if you get sick, your out-of-pocket costs will be higher and you may not be able to change plans.

  In addition to the $1,650 (in 2003) deductible that you must pay for the high deductible option on Plans F and J, you must also pay deductibles for:

  - Prescription drugs ($250 per year for Plan J), and
  - Foreign travel emergency ($250 per year for Plans F and J).

- **Whether you buy a Medicare SELECT Policy.**
  If you have a Medicare SELECT policy and you don't use a Medicare SELECT hospital or doctor for non-emergency services, you will have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter what hospital or doctor you choose.

Words in purple are defined on pages 82-85.

When Is The Best Time To Buy A Medigap Policy?

The best time to buy a Medigap policy is during your Medigap open enrollment period.

Your Medigap open enrollment period lasts for six months. It starts on the first day of the month in which you are both:

- Age 65 or older, **and**
- Enrolled in Medicare Part B.

Once the six-month Medigap open enrollment period starts, it can't be changed.

During this period, an insurance company can't:

- Deny you insurance coverage,
- Place conditions on a policy (like making you wait for coverage to start), or
- Charge you more for a policy because of past or present health problems.

If you buy a Medigap policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have. This is called "creditable coverage."

See page 36 for more information about pre-existing conditions. If you want to know more about creditable coverage, see page 37. If you are disabled or have End-Stage Renal Disease (ESRD), see pages 38-40.

You can tell if you are in your Medigap open enrollment period by looking at your red, white, and blue Medicare card. This card shows the dates that your Medicare Part A and Part B coverage started. If you are age 65 or older, add six months to the date that your Medicare Part B coverage starts. If that date is in the future, you are still in your Medigap open enrollment period. If that date is in the past, you have missed your Medigap open enrollment period (see example on page 19).

Words in purple are defined on pages 82-85.

When Is The Best Time To Buy A Medigap Policy? (continued)

Example: Medigap Open Enrollment Period

It is October 1, 2003, and Mr. Rodriguez wants to buy a Medigap policy. He needs to know if he is in his Medigap open enrollment period. He looks at his Medicare card. His Medicare Part B coverage started August 1, 2003. To figure out if he is in his open enrollment period, he must add six months to his Medicare Part B start date and see if it is before or after the current date.

August 1, 2003 + six months = January 31, 2004

Since it is October 1, 2003, he is still in his open enrollment period. Mr. Rodriguez has until January 31, 2004, to buy any Medigap policy during his Medigap open enrollment period.

What If I Missed My Medigap Open Enrollment Period?

If you apply for a Medigap policy after your open enrollment period has ended, the Medigap insurance company is allowed to use medical underwriting to decide whether to accept your application, and how much to charge you for the policy. If you are in good health, the insurance company is likely to accept your application, but there is no guarantee that you will get the policy.

Should I Enroll In Medicare Part B And Start My Medigap Open Enrollment Period If I Am Age 65 Or Older And Still Working?

You may want to wait to enroll in Medicare Part B if you or your spouse are working and have group health coverage through an employer or union based on your or your spouse's current or active employment. **Your Medigap open enrollment period won't start until you sign up for Medicare Part B.** Remember, once you're age 65 or older **and** enrolled in Medicare Part B, the Medigap open enrollment period starts and can't be changed.

Steps To Buying A Medigap Policy

Buying a Medigap policy is an important decision. Only you can decide if a Medigap policy is the right kind of health insurance coverage for you. If you decide to buy a Medigap policy, shop carefully. Look for a policy that you can afford and that gives you the coverage you need most. As you shop for a Medigap policy, keep in mind that different insurance companies may charge different amounts for the same type of Medigap policy.

The steps to buy a Medigap policy include the following:

Step 1: Look at how much you are spending on health care each year (see pages 21-22).

Step 2: Think about your future health care needs, review the Medigap plans, and decide which benefits you need or want (see pages 23-26).

Step 3: Find out which insurance companies sell Medigap policies in your state (see page 27).

Step 4: Call the insurance companies and compare costs (see pages 28-29).

Step 5: Choose the best Medigap policy for you (see page 30).

Step 6: Buy the Medigap policy (see page 31).

Step 1. Look at how much you are spending on health care each year.

Use the worksheet on page 22 to write down your yearly expenses for health care. If you don't know your yearly expenses, use the worksheet to check off the health care costs and services you paid for (called out-of-pocket costs) (see "How To Use The Worksheet" below). This will help you decide which Medigap policy benefits you need. It will also help you when you begin to shop for the Medigap policy that is right for you.

Important: If you are currently in a health plan that pays for the cost of these services, you may not know how much these services cost. However, you should think about your current and future health care needs, and place a check mark next to those items you think you may need. As you get older, your health care costs may increase.

How To Use The Worksheet

Column 1

- This column lists types of health care services that you may have paid for over the last few years. You can also add other health care services that you paid for in the past that you may want to think about when choosing a Medigap policy. Write those services in the row marked "Other."

Column 2

- Write down the cost for the services you used and paid for over the last few years, or place a check mark for health care costs you paid for.

- Look at the amounts in Column 2. Rows with the largest dollar or cost amounts are most likely the benefits you may need in a Medigap policy right now. Remember, you should also think about your future health care needs (see pages 24-25). For example, let us say you didn't have a hospital stay last year, so you didn't have to pay a Medicare Part A hospital deductible. Next year, or sometime in the future, you may end up in a hospital. If you didn't buy a Medigap policy that covers the Medicare Part A hospital deductible, you will have to pay this cost for each benefit period ($840 in 2003).

Words in purple are defined on pages 82-85.

Yearly Health Care Cost Worksheet

Column 1 Health Care Services	Column 2 How Much You Paid Last Year (Write down dollar amount or check if you paid last year.)
Skilled Nursing Coinsurance Up to $105 a day (in 2003) for days 21-100 in a Skilled Nursing Facility.	**$**
Medicare Part A Hospital Deductible This amount ($840 in 2003), for days 1-60 of a hospital stay, can change every year.	**$**
Medicare Part B Yearly Deductible $100 per year in 2003.	**$**
Medicare Part B Excess Charge This is the difference between your doctor's actual charge and Medicare's approved amount.	**$**
Foreign Travel Emergency Any emergency care you received outside of the United States.	**$**
At-Home Recovery Help you receive at home with activities of daily living, like bathing and dressing, when you are already getting Medicare-covered home health visits.	**$**
Prescription Drugs	**$**
Preventive Care Such as routine yearly check-ups, serum cholesterol screening, hearing tests, diabetes screening, and thyroid function tests.	**$**
Other	**$**

Step 2. Think about your future health care needs, review the Medigap plans, and decide which benefits you need or want.

If you decide to buy a Medigap policy, make sure it covers the benefits you want or need. **You should also think about benefits you may need in the future. Think about your medical history, your family medical history, and health risks when thinking about future health care costs.**

On the next two pages you will find a worksheet you can use. If you complete this worksheet, you should have a good idea of the types of benefits you want to look for in a Medigap policy. The worksheet includes a list of extra benefits that different Medigap policies cover. Next to each benefit is a reason why you might want or need that benefit.

1. Put a check mark in the column "Do I need or want these extra benefits?" next to the extra benefits you need or want.

2. Turn to the chart on page 15 that lists all the Medigap plans and their benefits. On that chart, circle the benefits you checked on the worksheet.

3. Look at the benefits you circled on page 15, and find the plan that has most, if not all, of the benefits you need or want. Remember, all of the plans cover the basic benefits (see below). The plan you choose may not match your needs exactly. You may have to give up or buy extra benefits to get a plan that is close to what you want.

These basic (core) benefits are included in all Medigap policies:

- The Medicare Part A coinsurance amount for days 61-90 ($210 per day in 2003), and days 91-150 ($420 per day in 2003) of a hospital stay,
- Coverage of up to 365 more days of a hospital stay during your lifetime after you use up all Medicare hospital benefits,
- The coinsurance or copayment amount for Medicare Part B services after you meet the $100 yearly deductible (in 2003), and
- The first three pints of blood or equal amounts of packed red blood cells per calendar year, unless this blood is replaced.

Medigap policy extra benefits	Reasons you might need or want these extra benefits	Do I need or want these extra benefits?
Skilled Nursing Coinsurance Up to $105 a day (in 2003) for days 21-100 in a Skilled Nursing Facility.	You may need this benefit if you have to go to a Skilled Nursing Facility (SNF) after a hospital stay and stay in the SNF longer than 20 days.	
Medicare Part A Hospital Deductible This amount ($840 in 2003), for days 1-60 of a hospital stay, can change every year.	You may need this benefit if you have to stay in the hospital. You have to pay the Medicare Part A deductible each benefit period.	
Medicare Part B Yearly Deductible $100 per year in 2003.	You may want to think about this benefit if you have Medicare Part B. Each year you must pay the Medicare Part B deductible before Medicare starts to pay its share. If you have this benefit, the Medigap policy would pay this amount each year.	
Medicare Part B Excess Charge This is the difference between your doctor's actual charge and Medicare's approved amount, if your doctor doesn't accept assignment. Plans F, I, and J pay all of the excess charges. Plan G pays 80% of the excess charges.	You may want to think about this benefit if your doctors don't accept assignment. You may also want this benefit if you have to stay in the hospital and can't control whether the doctors you see accept assignment. Under federal law, doctors who don't take Medicare's approved amount as payment in full (accept "assignment"), may charge up to 15% more than the approved amount. Your state may have different laws.	
Foreign Travel Emergency 80% of the cost of emergency care during the first 60 days of each trip (after the $250 deductible). Up to $50,000 in your lifetime.	You may want to think about this benefit if you travel outside the United States. This benefit could save you money if you need emergency care.	

Medigap policy extra benefits	Reasons you might need or want these extra benefits	Do I need or want these extra benefits?
At-Home Recovery This is the cost of at-home help with activities of daily living, like bathing and dressing, if you are already getting Medicare-covered home health visits. Up to eight weeks of at-home help after skilled nursing care is no longer needed. Will pay up to $40 each visit and $1,600 each year.	This benefit covers additional care at home if you are already getting Medicare-covered home health services. This benefit may add to the cost of the policy.	
Prescription Drugs 50% of the drug costs that Medicare doesn't cover (after you pay a $250 per year deductible). Up to $1,250 each year under Plans H and I (Basic drug benefit). Up to $3,000 each year under Plan J (Extended drug benefit).	You may want to think about this benefit if you have high prescription drug costs. It covers half your drug costs after the yearly deductible up to a maximum amount. Therefore, to get the full benefit under Plans H and I, you should have at least $2,750 in drug costs in a year (you pay $1,250 plus $250; plan pays $1,250). To get the full benefit under Plan J, you should have at least $6,250 in drug costs in a year (you pay $3,000 plus $250; plan pays $3,000).	
Preventive Care Such as routine yearly check-ups, serum cholesterol screening, hearing tests, diabetes screening, and thyroid function tests. Up to $120 each year.	This benefit helps pay for routine yearly check-ups and tests that may be important to keep you healthy.	

Step 2. Think about your future health care needs, review the Medigap plans, and decide which benefits you need or want. (continued)

Now that you have completed the worksheet (listed on pages 24-25) and have circled the benefits you need or want on the chart (listed on page 15), you should have a good idea of what Medigap plans best fit your needs. Next, you will need to find out which insurance companies sell Medigap policies in your state. Step 3 explains how to find this information (see page 27).

If you need more information about which Medigap policy is best for you, call your State Health Insurance Assistance Program (see pages 79-80).

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 73-75.

Step 3. Find out which insurance companies sell Medigap policies in your state.

To find out which insurance companies sell Medigap policies in your state, you can do any of the following:

- Call your State Health Insurance Assistance Program (see pages 79-80). Ask if they have a Medigap rate comparison shopping guide for your state. These types of guides usually list the insurance companies that sell Medigap policies in your state and compare the costs of policies for each company.
- Call your State Insurance Department (see pages 79-80).
- Look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder" (see page 40).

  This website will help you find information on all your health plan options, including Medigap policies in your area. You can also get information on the following:

  ✓ Some companies that sell Medigap policies in your state,

  ✓ What the policies must cover, and

  ✓ How insurance companies decide what to charge you for a Medigap policy premium.

  If you don't have a computer, your local library or senior center may be able to help you look at this information.

- Call 1-800-MEDICARE (1-800-633-4227). For English, press (1) or for Spanish, press (2). Select option "0." A Customer Service Representative will help you get information on all your health plan options, including Medigap policies in your area. You will get your Medicare Personal Plan Finder results in the mail within three weeks. TTY users should call 1-877-486-2048.

You should plan to call more than one insurance company that sells Medigap policies in your state. Make sure the ones you choose to call are honest and reliable (see page 55).

Step 4. Call the insurance companies and compare costs.

Call different insurance companies and ask questions (see page 29). Friends and relatives can tell you about their policies, but their policies may not fit your needs. Shop around for the best Medigap policy for you at a price you can afford.

If you aren't in your Medigap open enrollment period or in another situation where you have a guaranteed issue right to buy a Medigap policy (see pages 41-48), ask questions. You should ask each insurance company the questions listed on page 29.

Use the comparison worksheet on page 29 to write down the insurance company answers. This will help you compare costs and benefits you are considering.

Medigap Policy Comparison Worksheet

Use this worksheet to compare costs and benefits you are considering. **Make sure you get the agents' and the companies' names, addresses, and telephone numbers.**

Ask each insurance company	Insurance Company 1	Insurance Company 2	Insurance Company 3
Is this insurance company licensed in this state? (The answer should be yes.)			
Which Medigap policies do you sell? (Make sure they sell the plan you want.)			
What is the cost, this year, of the Medigap policy I am interested in? What has been the cost of this Medigap policy for the past few years?			
How is the price decided? • What type of pricing does this insurance company use? • Does it make a difference if I am male or female? • Does it make a difference if I smoke or don't smoke? • Does it make a difference if I am married or single?			
Are there any additional ("innovative") benefits or discounts included in this policy?			
If you aren't in your Medigap open enrollment period or in another situation where you have a guaranteed issue right, ask: • Will you accept my application? • Do you review my health records or application to decide how much to charge me for a Medigap policy? • Will I have to wait for my pre-existing conditions to be covered if I already have a health problem?			

Step 5. Choose the best Medigap policy for you.

After you call the insurance companies and compare their costs, choose the Medigap policy that is best for you.

But, before you make your final choice, make sure of the following:

- ☐ You carefully review the Medigap policy benefits.
- ☐ You can afford the cost of the policy.
- ☐ The policy covers the benefits you need and want.
- ☐ You feel good about and trust the insurance company and/or the insurance agent.
- ☐ You talk with someone you trust, like a family member, friend, doctor, or insurance agent about your choice.

Once you have checked the items above, you are now ready to move on to Step 6.

Step 6. Buy the Medigap policy.

Once you have decided on the insurance company and the Medigap policy you want, you can buy your policy. The insurance company must give you a clearly worded summary of your Medigap policy. Read it carefully. If you don't understand it, ask questions. Remember the following when you buy your Medigap policy:

- ☐ Fill out your application carefully and completely. Answer all of the medical questions. If the insurance agent fills out the application, review it to make sure it's correct.

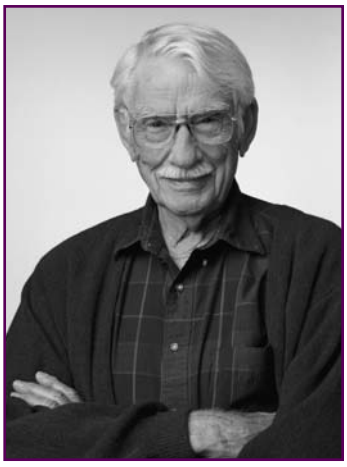
- ☐ Don't buy more than one Medigap policy. If you already have a Medigap policy, it is illegal for an insurance company to sell you a second policy unless you put in writing that you are going to cancel the first Medigap policy. However, don't cancel your first Medigap policy until the second one is in place, and you decide to keep the second Medigap policy. You have 30 days to decide if you want to keep the new policy. This is called your "free look" period.

- ☐ Don't pay cash. Pay for your policy by check, money order, or bank draft. Make it payable to the insurance company, not the agent.

- ☐ Ask for your Medigap policy to become effective when you want coverage to start, or when your previous policy coverage ends. If, for any reason, the insurance company won't give you the start date you want, call your State Insurance Department (see pages 79-80).

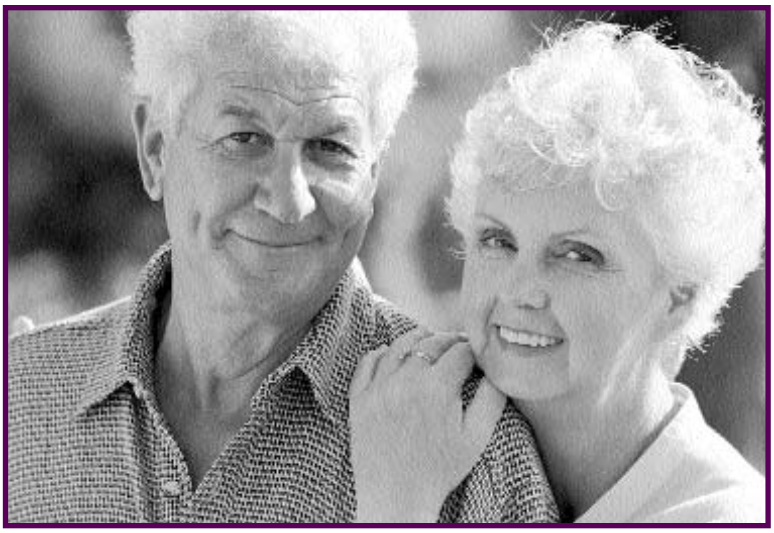
- ☐ Get a receipt with the insurance company's name, address, and telephone number for your records.

- ☐ Make sure you get a copy of your policy within 30 days. If you don't get your policy in 30 days, call your insurance company. If you don't get your policy in 60 days, call your State Insurance Department (see pages 79-80).



“I keep this book on my shelf so I know where to find it if I have a question.”

Section 3: More Detailed Medigap Policy Information



"Before we bought a Medigap policy, we used this section to learn more about Medigap policies."

Ways of Pricing Medigap Policies

Insurance companies have three different ways of pricing Medigap policies based on your age:

1. No-age-rated (also called community-rated)
2. Issue-age-rated
3. Attained-age-rated

1. No-age-rated (also called community-rated) policies

These policies charge everyone the same rate no matter how old they are.

*** Example: No-age-rated**
Mrs. Smith pays the same monthly premium at each age plus any premium increases the company may charge because of inflation.

Monthly Premium at Age 65	$155
Monthly Premium at Age 75	$155
Monthly Premium at Age 85	$155

2. Issue-age-rated policies

The monthly premium for these policies is based on your age when you first buy the policy. The cost doesn't go up automatically as you get older. Your premium will be the same as anyone your age buying this policy for the first time.

*** Example: Issue-age-rated**
Mrs. Smith pays the same monthly premium depending on how old she is when she buys the policy. She also pays any additional premium increase the company may charge because of inflation.

Buy Policy at Age 65

Monthly Premium at Age 65	$130
Monthly Premium at Age 75	$130
Monthly Premium at Age 85	$130

Buy Policy at Age 75

Monthly Premium at Age 75	$165
Monthly Premium at Age 85	$165

Buy Policy at Age 85

Monthly Premium at Age 85	$195

Ways of Pricing Medigap Policies (continued)

3. Attained-age-rated policies

The monthly premiums for these policies are based on your age each year. These policies generally cost less at age 65, but their costs go up automatically as you get older.

Caution: In general, attained-age-rated policies are cheaper than issue-age-rated policies the first few years you own the policy. However, rate increases for attained-age-rated policies are usually larger than rate increases for issue-age-rated policies. After a period of time, the premiums for an attained-age-rated policy will be higher than what the premiums would have been if you had an issue-age-rated policy.

* **Example: Attained-age-rated**

Mrs. Smith buys the policy at age 65, and pays higher monthly premiums as she gets older. She also pays any additional premium increases the company may charge because of inflation.

Monthly Premium at Age 65	$115
Monthly Premium at Age 75	$160
Monthly Premium at Age 85	$200

* Remember, **all** monthly premiums may change and go up each year because of inflation and rising health care costs. Also, the amounts shown in the examples aren't actual costs. Cost may vary.

Medigap Coverage of Pre-existing Conditions

What Is A Pre-existing Condition?

A pre-existing condition is a health problem you had before the date a new insurance policy starts.

Will My Pre-existing Condition Be Covered If I Buy A Medigap Policy?

In some cases, a Medigap insurance company can refuse to cover health problems for up to six months, if you had the health problem before the policy started. This is called a "pre-existing condition waiting period." The insurance company can only use this kind of waiting period if your health problem was diagnosed or treated during the six months before the policy started. This means that the insurance company can't make you wait for coverage of a pre-existing condition just because it thinks you should have known to see a doctor for a health problem.

Open Enrollment Period

If you buy a policy during your Medigap open enrollment period, and you had at least six months of previous health coverage that qualifies as "creditable coverage" (see page 37), the company cannot give you any pre-existing condition waiting period. If you had less than six months of creditable coverage, this waiting period will be reduced by the number of months of creditable coverage you had.

Special Medigap Protections (Guaranteed Issue Rights)

If you buy a Medigap policy when you have special Medigap protections or guaranteed issue rights, the insurance company can't use a pre-existing condition waiting period (see page 41).

If you want to know if you will have a pre-existing condition waiting period if you switch Medigap policies, see page 50.

Words in purple are defined on pages 82-85.

Creditable Coverage

What Is Creditable Coverage?

Creditable coverage is any previous health coverage you have that can reduce the time you have to wait before your pre-existing health conditions will be covered by a policy you buy during your Medigap open enrollment period.

Your previous health coverage could have been any of the following:

- A group health plan (like an employer plan)
- A health insurance policy
- Medicare Part A or Medicare Part B
- Medicaid (see page 60)
- A medical program of the Indian Health Service or tribal organization
- A state health benefits risk pool
- TRICARE (the health care program for military dependents and retirees [see pages 65-66])
- A Federal Employees Health Benefit Plan
- A public health plan
- A health plan under the Peace Corps Act

Note: Whether you can use creditable coverage depends on whether you had any "breaks in coverage." If there was any time when you had no health coverage of any kind, and, during that time, you were without coverage for more than 63 days in a row, you can only count creditable coverage that you had after that break in coverage.

Example: Creditable Coverage

Mr. Smith is 65 and has heart disease. His Medicare Part A and Part B started November 1, 2002. Before this date, he had no health insurance coverage. On March 1, 2003, Mr. Smith buys a Medigap policy. His Medigap insurance company refuses to cover his heart disease condition for six months (the pre-existing condition waiting period). However, since Mr. Smith had Medicare Part A and Part B from November 1 to March 1, the insurance company must use his four months of Medicare coverage as creditable coverage to shorten this six-month waiting period. Now his waiting period will only be two months instead of six months. During these two months, after Medicare pays its share, Mr. Smith will have to pay the rest of the costs for the care of his heart disease. He will also have to pay his Medigap premiums.

Medigap Policies For People Under Age 65 With A Disability or End-Stage Renal Disease (ESRD)

You may have Medicare before age 65 due to the following:

- A disability, or
- ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

If you are under age 65 and disabled or have ESRD, you may not be able to buy the Medigap policy you want until you turn 65. Federal law doesn't require insurance companies to sell Medigap policies to people under age 65. However, some states require insurance companies to sell you a policy, at certain times, even if you are under age 65.

During the first six months after you turn age 65 **and** are enrolled in Medicare Part B, you will get a Medigap open enrollment period. It doesn't matter that you have had Medicare Part B before you turned age 65. During this time:

- You can buy any Medigap policy (including those policies that help pay the cost of prescription drugs), and
- Insurance companies cannot refuse to sell you a Medigap policy due to a disability or other health problem, or charge you a higher premium than they charge other people who are 65 years old.

When you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of creditable coverage you have. If you had Medicare for more than six months before you turned 65 years old, you won't have a pre-existing condition waiting period because Medicare counts as creditable coverage. (See page 37 for more information about creditable coverage.)

Several states require Medigap insurance companies to offer a limited Medigap open enrollment period for people with Medicare Part B who are under age 65. At the time of this printing, the following states require insurance companies to

Medigap Policies For People Under Age 65 With A Disability or End-Stage Renal Disease (ESRD) (continued)

offer at least one kind of Medigap policy during a special open enrollment period to people with Medicare under age 65:

- California
- Connecticut
- Kansas
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Mississippi
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Texas
- Washington
- Wisconsin

Also, some insurance companies will sell Medigap policies to people with Medicare under age 65. However, these policies may cost you more. Remember, if you live in a state that has a Medigap open enrollment period for people under age 65, you will still get another Medigap open enrollment period when you turn age 65.

Also, if you join a Medicare + Choice Plan and your coverage ends, you may have the right to buy a Medigap policy (see "Special Note For People With Medicare Under Age 65" on page 48). If you have questions, you should call your State Health Insurance Assistance Program (see pages 79-80).

"I wasn't sure if I could buy a Medigap policy, so I called my State Health Insurance Assistance Program. They were very helpful and answered all of my questions."

Right to suspend a Medigap policy for disabled people with Medicare

If you are under 65, have Medicare, and have a Medigap policy, you have a right to suspend your Medigap policy. You can suspend your Medigap policy benefits and premiums, without penalty, while you are enrolled in your or your spouse's employer group health plan.

If, for any reason, you lose your employer group health plan coverage, you can get your Medigap policy back. You must notify your Medigap insurance company that you want your Medigap policy back within 90 days of losing your employer group health plan coverage.

Right to suspend a Medigap policy for disabled people with Medicare (continued)

Your Medigap benefits and premiums will start again on the day your employer group health plan coverage stops. The Medigap policy must have the same benefits and premiums it would have had if you had never suspended your coverage. Your Medigap insurance company can't refuse to cover care for any pre-existing conditions you have. So, if you are disabled and working, you can enjoy the benefits of your employer's insurance without giving up your Medigap policy.

Information on Medicare Health Plans and Medigap Policies

Choosing the right health coverage is an important - but sometimes difficult - decision. The "Medicare Personal Plan Finder" helps you find information on your health plan options, including Medigap policies in your area. You will be able to get information about some of the insurance companies that sell Medigap policies in your state, how to contact these insurance companies, and, in some cases, how to compare your Medigap policy choices.

"I used my computer to get a great start on my search for the right Medigap policy."

You can get information three ways:

1. Visit www.medicare.gov on the web for fast results. Select "Medicare Personal Plan Finder."
2. Call 1-800-MEDICARE (1-800-633-4227). For English, press (1) or for Spanish, press (2). Select option "0." A Customer Service Representative will help you. You will get your Medicare Personal Plan Finder results in the mail within three weeks.
3. Call your State Health Insurance Assistance Program (see pages 79-80). Ask if they have a Medigap rate comparison shopping guide for your state.

Medicare Personal Plan Finder Results

When you use the Medicare Personal Plan Finder, you will get a personalized summary page with general information to help you compare Medicare health plans and Medigap policies in your area. You can also get detailed information about the Medicare health plans and Medigap policies available in your area, or just the ones you are most interested in. You should plan to call more than one insurance company that sells Medigap policies in your state. Make sure the ones you call are licensed and reliable (see page 55).

Medigap Rights and Protections (Guaranteed Issue Rights)

Your Rights To Buy A Medigap Policy

In some situations, you have the right to buy a Medigap policy outside of your Medigap open enrollment period. These rights are called "Medigap protections." They are also called guaranteed issue rights because the law says that insurance companies must sell you a Medigap policy.

In these situations, an insurance company:

- Can't deny you Medigap coverage or place conditions on a policy (like making you wait for coverage to start),
- Must cover you for all pre-existing conditions, and
- Can't charge you more for a policy because of past or present health problems.

In many cases, these rights also apply when your health coverage changes. Remember, it is best not to wait until your current health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (for example, while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage.

Note: If you drop your Medigap policy, you may not be able to get it back except in very limited cases.

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, you have the same guaranteed issue rights to buy a Medigap policy. If you have questions, call your State Insurance Department (see pages 79-80).

Summary of Medigap Protections If You Lose or Drop Your Health Care Coverage (Guaranteed Issue Rights)

The following page has a summary of these situations. In order to get these Medigap protections, you must meet certain conditions. More detailed information on each situation will follow the summary. All rights to buy Medigap policies in the following situations include Medicare SELECT policies since they are a type of Medigap policy.

Note: There may be times when more than one situation applies to you. When this happens, you can choose the protection that gives you the best choice of Medigap policies.

Summary of Medigap Protections (continued)

Situation #1: Your Medicare + Choice Plan or PACE program coverage ends because the plan is leaving the Medicare program or stops giving care in your area (see pages 43-44).

Situation #2: Your employer group health plan coverage ends (see page 44).

Situation #3: You have to end your health coverage because you move out of the plan's service area (see page 45).

Situation #4: You joined a Medicare + Choice Plan or PACE program when you were first eligible for Medicare at age 65. Within the first year of joining, you decide you want to leave (see page 45).

Situation #5: You dropped a Medigap policy to join a Medicare + Choice Plan, Medicare SELECT policy, or PACE program for the first time and now you want to leave. You have been in the plan less than a year (see page 46).

Situation #6: Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own (see page 46).

Situation #7: You leave your plan because your Medicare + Choice Plan, Medicare SELECT, or Medigap insurance company has committed fraud. For example, the marketing materials were misleading, or quality standards were not met (see page 47).

Important: In some situations, you have a guaranteed issue right to buy a Medigap policy because you lost certain kinds of health coverage. You should keep a copy of any letters, notices, and claim denials you get. Be sure to keep anything that has your name on it. Also, keep the postmarked envelope these papers come in. You may need to send a copy of some or all of these papers with your application for a Medigap policy to prove you lost coverage and have the right to these Medigap protections. The Medigap protections in this section are from Federal law. Many states provide more Medigap protections than Federal law. Call your State Health Insurance Assistance Program or State Insurance Department for more information (see pages 79-80).

Medigap Protections

Situation #1: Your Medicare + Choice Plan or PACE program coverage ends because the plan is leaving the Medicare program or stops giving care in your area.

In this situation, your Medicare + Choice Plan or PACE program sends you a letter telling you that you will no longer be covered by the plan. You have the right to buy Medigap plan A, B, C, or F that is sold in your state by any insurance company. You can buy the policy at the best premium price available, with no review of your medical records even if you have health problems.

You can apply for a Medigap policy as soon as you get the final notification letter from your plan. When you get this letter telling you that your plan is leaving the Medicare program or will no longer give care in your area, you may have three choices:

1. Switch to another Medicare + Choice Plan in your area. The final notification letter will tell you if there are other plans available in your area. In some cases, you may have to wait until the new plan you want to join is accepting new members. **If you join a new Medicare + Choice Plan when your current plan coverage ends, you won't need (or be able to use) a Medigap policy.**

2. Leave your Medicare + Choice Plan or PACE program (disenroll) any time between the date you get your final notification letter and when your health coverage ends. Unless you join another Medicare + Choice Plan, you will automatically return to the Original Medicare Plan when you leave (disenroll from) your plan or PACE program. **You have 63 calendar days from the day you leave your plan or PACE program to apply for a Medigap policy.**

3. Stay in your plan or PACE program until the date your coverage ends. Unless you join another Medicare + Choice Plan, you will automatically return to the Original Medicare Plan when your coverage ends. **You have 63 calendar days after your health coverage ends to apply for a Medigap policy.**

The Programs of All-inclusive Care for the Elderly (PACE) combines medical, social, and long-term care services for frail people. PACE is available only in states that choose to offer it under Medicaid. For more information about PACE, see page 61.

Medigap Protections (continued)

Situation #1: Your Medicare + Choice Plan or PACE program coverage ends because the plan is leaving the Medicare program or stops giving care in your area. (continued)

Important: You will have additional rights under Situation #4 (see page 45) or Situation #5 (see page 46) if:

- This was the first time you were in a Medicare + Choice Plan,
- You were in the plan less than one year before the plan left the Medicare program or stopped giving care in your area, and
- You choose to return to the Original Medicare Plan and apply for a Medigap policy.

If, instead, you immediately join another Medicare + Choice Plan, you can stay in that plan for up to one year and still have the rights described in Situations #4 and #5.

Situation #2: Your employer group health plan coverage ends.

You are in an employer group health plan that pays **some or all** of the costs not paid by Medicare, but plan coverage ends because the employer goes out of business or cancels your company coverage. You have the right to buy Medigap plan A, B, C, or F that is sold in your state by any insurance company. You can buy the policy at the best premium price available, with no review of your medical records even if you have health problems.

You may get a letter or a notice from your employer, the health plan, or insurance company telling you your coverage has been or will be cancelled. You have 63 calendar days from the date your coverage ends or from the date on the letter or notice (whichever is later) to apply for a Medigap policy. In some cases, you won't get a notice, but you may get a claim denial. If this happens, this claim denial is the same as a letter telling you that your coverage has ended. Remember, keep a copy of the letter, notice, claim denial, and postmarked envelope. You may need these papers to prove you lost coverage. You will need to send a copy of the letter, notice, or claim denial with your application in order to buy a Medigap policy.

Note: If you are covered by your spouse's employer group health plan (EGHP), and she/he retires, you will get guaranteed issue rights if your employer group health plan coverage is cancelled because you can no longer be covered under the terms of the plan. You will have guaranteed issue rights when your COBRA coverage is exhausted.

Medigap Protections (continued)

Situation #3: You have to end your health coverage because you move out of the plan's service area.

If you have health coverage from a Medicare + Choice Plan, a Medicare SELECT policy, or you are in a PACE program, and you move out of the plan's service area, you will have to end your coverage. You have the right to buy Medigap plan A, B, C, or F that is sold in your state, or the state you are moving to, from any insurance company. You can buy the policy at the best premium price available, with no review of your medical records even if you have health problems.

You must tell your current plan that you are moving and give them a date when you will end your coverage. You can apply for a Medigap policy as early as 60 calendar days before the date your health coverage ends. You must apply for a Medigap policy no later than 63 calendar days after your health coverage ends.

Situation #4: You joined a Medicare + Choice Plan or PACE program when you were first eligible for Medicare at age 65. Within the first year of joining, you decide you want to leave.

You have the right to buy any Medigap policy that is sold in your state by any insurance company. You can buy the policy at the best premium price available, with no review of your medical records even if you have health problems. You must tell the plan that you want to leave (disenroll) and give them a date to end your coverage. You will have from 60 calendar days before your coverage ends until 63 calendar days after your coverage ends to apply for a new Medigap policy.

Your rights under this situation may last for an extra 12 months if the plan you first joined leaves the Medicare program or stops giving care in your area before you have been in the plan for one year, AND you immediately join another Medicare + Choice Plan or PACE program.

Medigap Protections (continued)

Situation #5: You dropped a Medigap policy to join a Medicare + Choice Plan, Medicare SELECT policy, or PACE program for the first time and now you want to leave. You have been in the plan less than a year.

You have the right to go back to your former Medigap policy, only if the same insurance company still sells it. You need to tell the Medicare + Choice Plan, Medicare SELECT, or PACE program or policy that you want to leave (disenroll) and give them a date to end your coverage. This date must be before you have been in the plan for a year.

If your former Medigap policy isn't available, you have the right to buy Medigap plan A, B, C, or F that is sold in your state by any insurance company. You can buy the policy at the best premium price available, with no review of your medical records even if you have health problems. You will have from 60 calendar days before your coverage ends until 63 calendar days after your coverage ends to apply for a new Medigap policy.

Your rights under this situation may last for an extra 12 months if the plan you first joined leaves the Medicare program or stops giving care in your area before you have been in the plan for one year, AND you immediately join another Medicare + Choice Plan or PACE program.

Situation #6: Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.

You have the right to buy Medigap plan A, B, C, or F that is sold in your state by any insurance company. You can buy the policy at the best premium price available, with no review of your medical records even if you have health problems. You will have 63 calendar days from the date your coverage ends to apply for a new Medigap policy.

Words in purple are defined on pages 82-85.

Medigap Protections (continued)

Situation #7: You leave your plan because your Medicare + Choice Plan, Medicare SELECT, or Medigap insurance company has committed fraud.

In this situation, you leave the health plan because it failed to meet its contract obligations to you. For example, the marketing materials were misleading, or quality standards weren't met. Generally, you must have filed a grievance with the health plan, Medicare, or the State Insurance Department and received a decision that the plan was at fault before you have this right.

You have the right to buy Medigap plan A, B, C, or F that is sold in your state by any insurance company. You can buy the policy at the best premium price available, with no review of your medical records even if you have health problems. You must tell the plan that you want to leave (disenroll) and give them a date to end your coverage. You will have 63 calendar days from the date your coverage ends to apply for a new Medigap policy.

Remember, some states provide more Medigap protections. Your state may let you choose from more Medigap policies or give you a longer time to apply for a Medigap policy when you lose your coverage. Call your State Health Insurance Assistance Program (see pages 79-80).

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, you have the same guaranteed issue rights (see pages 41-42) to buy a Medigap policy. If you have questions, call your State Insurance Department (see pages 79-80).

Medigap Protections (continued)

Special Note For People With Medicare Under Age 65

If you are in a situation that gives you the right to buy a Medigap policy, you must be allowed to buy Medigap plan A, B, C, or F that is sold in your state to people under age 65. You can buy the policy at the best premium price available, with no review of your medical records. However, there is no Federal law that says insurance companies must sell Medigap policies to people under age 65. If an insurance company does sell these Medigap policies to anyone under age 65, they must sell one to you if you are in one of these situations (listed on pages 43-47).

Special Note For People With End-Stage Renal Disease (ESRD)

If you have ESRD and are in a Medicare + Choice Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare + Choice Plan. You don't have to use your one-time right to join a new Medicare + Choice Plan immediately. If you change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare + Choice Plan at a later date as long as you are in a managed care election period.

Where To Get More Information About Medigap Protections

- Call your State Health Insurance Assistance Program (see pages 79-80) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that is right for you.
- Call your State Insurance Department (see pages 79-80) if you are denied Medigap coverage.

Losing Medigap Coverage

Can My Medigap Insurance Company Drop Me?

In most cases, no. If you bought your Medigap policy after 1990, the law says that your insurance company must let you renew your Medigap policy as long as you pay your premium. This means that the policy is guaranteed renewable. Your insurance company can drop you if you lie (for example, you commit fraud under the policy). Other than that, there is only one situation where you may lose a Medigap guaranteed renewable policy: if the insurance company goes bankrupt. If this happens, and state law doesn't make some other coverage available, you have the right to buy Medigap plan A, B, C, or F that is sold in your state (see Medigap Protections, Situation #6 on page 46).

Insurance companies in some states may refuse to renew Medigap policies that you bought before 1990. In order for an insurance company to refuse to renew one of these older Medigap policies, the company must get the state's approval and cancel all policies of this type that they sell in your state. If this happens, you have the right to buy Medigap plan A, B, C, or F that is sold in your state (see example below and Medigap Protections, Situation #6 on page 46).

Example:

In 1987, Mr. Jones bought a Medigap policy from Company X. The Medigap policy Mr. Jones bought is not guaranteed renewable because he bought it before 1990, and it didn't say it was guaranteed renewable. Company X won't renew Mr. Jones's policy because it is no longer being offered. The company is canceling all policies of this type in the state. Therefore, Mr. Jones has the right to buy Medigap plan A, B, C, or F that is sold in his state from any insurance company that offers them.

Words in purple are defined on pages 82-85.

Switching Medigap Policies

Do I Have To Switch If I Have An Older Medigap Policy?

No. If you have an older Medigap policy, you can keep it. You don't have to switch to one of the newer standardized Medigap plans. But, if you decide to switch your Medigap policy, you won't be able to go back to your older Medigap policy if you bought it before 1992 when standardized policies were first sold.

What Should I Do Before Switching My Medigap Policy?

Before switching policies, compare benefits and premiums. Some of the older Medigap policies may offer better coverage, especially for prescription drugs and long-term care. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies.

Do I Have To Wait A Certain Length Of Time Before I Can Switch To A Different Medigap Policy?

No, but the length of time you had your policy will affect how your new policy covers you for pre-existing conditions. Your new Medigap policy generally must cover all pre-existing conditions if you have had your current policy at least six months.

Your new Medigap policy might not cover all pre-existing conditions if you've had your current Medigap policy for less than six months. However, the amount of time you've had your current Medigap policy must count towards the amount of time you must wait before your new policy covers your pre-existing condition.

Words in purple are defined on pages 82-85.

Do I Have To Wait A Certain Length Of Time Before I Can Switch To A Different Medigap Policy? (continued)

If there is a benefit in the new Medigap policy that wasn't in your older policy, the company can make you wait up to six months before providing that benefit.

How Your Bills Get Paid

Does The Medigap Insurance Company Pay My Doctor Or Provider Directly?

When you have a Medigap policy, the insurance company must pay your doctor or provider directly when:

- Your doctor or provider has signed an agreement with Medicare to accept assignment of all Medicare claims for all their Medicare patients, and
- You tell your doctor's office to put on the Medicare claim form that you want Medigap insurance benefits paid to the doctor or supplier. Your doctor should put your Medigap policy number and the company name on the Medicare claim form. You will need to sign the claim form or have your doctor keep your signature on record. Make sure this information is correct.

When these conditions are met, the Medicare carrier will process the claim and send it to the Medigap insurance company. A Medicare carrier is a private company that has a contract with Medicare to pay Part B bills. The carrier will send you a Medicare Summary Notice. Your Medigap insurance company will pay your doctor or provider directly and then send you a notice. If you don't get this notice, you may ask your Medigap insurance company for it.

In most cases, Medicare claims are sent directly to the insurance company, even if the doctor doesn't accept assignment on all claims.

If Your Doctor Is Not Paid Directly

If the Medigap insurance company doesn't pay your doctor directly when the above two conditions are met, you should report this to your State Insurance Department (see pages 79-80). For more information on Medigap claim filing by the carrier, call your Medicare carrier. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number of the Medicare carrier in your state. TTY users should call 1-877-486-2048.

Words in purple are defined on pages 82-85.

Private Contracts

What Is A Private Contract?

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to the services you get from the doctor who asked you to sign it.

If I Sign A Private Contract With My Doctor, Will Medicare And My Medigap Policy Pay?

Medicare and Medigap policies won't pay for the services you get from the doctor with whom you have a private contract. You can't be asked to sign a private contract in an emergency or urgent health situation.

Note: You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor:

- Medicare health plans won't pay any amount for the services you get from this doctor.
- You will have to pay whatever this doctor or provider charges you for the services you get. Medicare's limiting charge won't apply.
- No claim should be submitted to Medicare, and Medicare won't pay if one is submitted.
- Your Medigap policy, if you have one, won't pay anything for this service. Call your Medigap insurance company before you get the service if you have any questions.
- Many other insurance plans won't pay for the services either. Call your insurance company before you get the service if you have any questions.
- Your doctor must tell you whether Medicare would pay for the service if you get it from another doctor who participates in Medicare.
- Your doctor must tell you if he or she has been excluded from the Medicare program.

You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see pages 79-80).

Watch Out for Illegal Insurance Practices

It is illegal for anyone to do the following:

- Pressure you into buying a Medigap policy, or lie to you or mislead you to get you to switch from one company or policy to another.
- Sell you a second Medigap policy when they know that you already have one, unless you tell the insurance company in writing that you plan to cancel your existing Medigap policy.
- Sell you a Medigap policy if they know you have Medicaid, except in certain situations (see page 60).
- Sell you a Medigap policy if they know you are enrolled in a Medicare + Choice Plan.
- Claim that a Medigap policy is part of the Medicare program or any other Federal program. Remember, Medigap is private health insurance.
- Sell you a Medigap policy that can't legally be sold in your state. Some Medigap insurance companies use direct mail advertising to sell policies. Check with your State Insurance Department to make sure that the Medigap plan you are interested in can be sold in your state.
- Misuse the names, letters, symbols, or emblems of the U. S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Centers for Medicare & Medicaid Services (CMS), or any of their various programs like Medicare.

If you believe that a Federal law has been broken, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. In most cases, however, your State Insurance Department can help you with insurance-related problems (see pages 79-80).

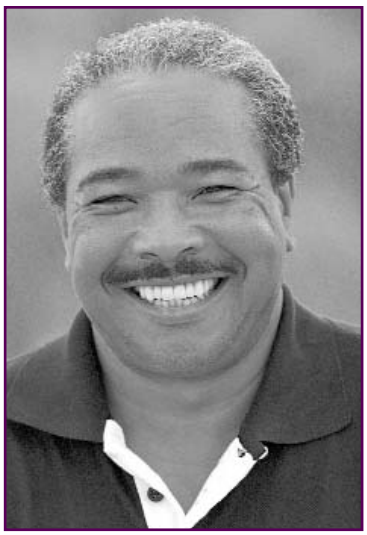
Ways To Check If An Insurance Company Is Reliable

Buying a Medigap policy is an important decision. You want to make sure that you are buying from a reliable insurance company. To help you find out if an insurance company is reliable, you can take the following actions:

- Call the State Insurance Department in your state (see pages 79-80). Ask if they keep a record of complaints against insurance companies and whether these can be shared with you.
- Go to your local public library. Your local public library can help you:
  - Get information on an insurance company's financial strength by independent rating services such as, Weiss Rating, Inc., A.M. Best, and Standard & Poors, and
  - Use the computer to look at information on the web.
- Talk to someone you trust, like your insurance agent or a friend who has a Medigap policy.
- Call the State Health Insurance Assistance Program in your state (see pages 79-80). These programs can give you free help with buying a Medigap policy.

Words in purple are defined on pages 82-85.

"I used this Guide to choose my Medigap policy."



Section 4: Other Ways To Pay Health Care Costs

"This section has helpful information about other ways to pay for my health care."

Other Kinds of Insurance and Ways To Pay Health Care Costs

There are other kinds of health coverage, besides a Medigap policy, that may pay for some of your health care costs not covered by Medicare. They include the following:

For more information about these kinds of health insurance and ways to pay health care costs, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Ask for a free copy of the *Health Care Coverage Directory for People with Medicare* (CMS Pub. No. 02231) and *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). You can also read or print a copy of these booklets at www.medicare.gov on the web. Select "Publications."

Medicare Savings Programs (Help From Your State)

There are programs that help millions of people with Medicare save money each year. States have programs for people with limited income and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance.

You can apply for these programs if:

- You have Medicare Part A, (If you are eligible for Medicare Part A but don't have it because you can't afford it, there is a program that may pay the Medicare Part A premium for you.) **and**
- You are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds, **and**
- You are an individual with a monthly income of less than $1,031,* or a couple with a monthly income of less than $1,384.*

* Income limits will change slightly in 2004. If you live in Alaska or Hawaii, income limits are slightly higher.

Medicare Savings Programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

Note: Individual states may have more generous income and/or resource requirements.

Call your State Medical Assistance Office and ask for information on Medicare Savings Programs. If you need the telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

State Children's Health Insurance Program (SCHIP)

Free or low-cost health insurance is available now in your state for uninsured children under age 19. State Children's Health Insurance Programs help reach uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. Information on your State's program is available through Insure Kids Now at 1-877-KIDS-NOW (1-877-543-7669). You can also look at www.insurekidsnow.gov on the web for more information.

Words in purple are defined on pages 82-85.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for some people with limited incomes and resources. Most of your health care costs are covered if you have Medicare and you qualify for Medicaid. Medicaid programs vary from state to state. People with Medicaid may get coverage for nursing home care and outpatient prescription drugs that aren't covered by Medicare. For more information about Medicaid, call your State Medical Assistance Office.

What should I do if I have a Medigap policy and then get Medicaid?

You have the right to suspend the Medigap policy rather than drop it while you have Medicaid. However, in some cases, it may not be a good idea to suspend your Medigap policy. Call your State Medical Assistance Office to help you with this decision.

If you do suspend your policy, while it is suspended, you don't pay premiums and it won't pay benefits. You can only suspend a Medigap policy for up to two years. At the end of the suspension, you can start it again without new medical underwriting or pre-existing condition waiting periods. Call your insurance company to find out how to suspend a policy.

Can An Insurance Company Sell Me A Medigap Policy If I Already Have Medicaid?

If you have Medicaid, an insurance company can sell you a Medigap policy only in certain situations (see chart below).

If Medicaid pays your Medigap policy premium...	The insurance company can legally sell you any Medigap policy
If Medicaid pays your Medicare premiums, deductibles, or coinsurance...	The insurance company can legally sell you Medigap plans H, I, or J
If Medicaid only pays all or part of your Medicare Part B premium...	The insurance company can legally sell you any Medigap policy

In any other situation, it is illegal for an insurance company to sell you a Medigap policy if you have Medicaid.

The PACE Program (Programs of All-inclusive Care for the Elderly)

PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must meet the following criteria:

- Be age 55 or older,
- Live in the service area of a PACE program,
- Be certified as eligible for nursing home care by the appropriate state agency, and
- Be able to live safely in the community.

If you are enrolled in a PACE program, you may have to pay a monthly premium depending on your Medicare or Medicaid eligibility.

Services are given by a team of health care professionals. The services are usually given in a PACE center and include home and transportation services. Services include primary health services, physical and occupational therapy, social services, personal care and support services, nutrition counseling, and meals. The goal of PACE is to help people stay independent and living in their community as long as possible, while getting the high quality care they need.

To find out if you are eligible, to find if there is a PACE site near you, or for more information, call your State Medical Assistance Office. If you need the telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information about PACE, you can also look at www.medicare.gov/Nursing/Alternatives/PACE.asp on the web for PACE locations and telephone numbers.

Words in purple are defined on pages 82-85.

Federally Qualified Health Centers (FQHCs)

These are special health centers that can give you routine health care at a lower cost. FQHCs may include the following:

- A community health center,
- Tribal health clinic,
- Migrant health service, and
- Health center for the homeless.

To find the FQHC nearest you, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Ask for the telephone number of the Primary Care Association in your state.

Home and Community-Based Service/Waiver Programs (HCBS)

The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults. These programs give quality and low cost services.

To get more information on HCBS programs, services, and eligibility, call your State Medical Assistance Office. If you need the telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also look at www.medicare.gov on the web. Select "Helpful Contacts." Select the state you want and select "Other Health Insurance Programs."

Employee or Retiree Coverage from an Employer or Union

Call the benefits administrator at your or your spouse's current or former employer or union. Ask if you have or can get health care coverage based on your or your spouse's past or current employment. Since this kind of health coverage isn't a Medigap policy, the rules that apply to Medigap policies don't apply.

Note: When you have retiree coverage from an employer or union, they manage this coverage. They may change the benefits or premiums, and may also cancel the coverage if they choose.

> **Caution:** If you drop your employer or union group health coverage, you may not be able to get it back. For more information, call your employer's or union's benefits administrator.

Important: If the employer or union health coverage ends, you may have the right to buy a Medigap policy. Your employer or union must tell you within 60 calendar days after the date your coverage ends. If they don't, your only notice that your coverage has ended could be a letter telling you that your claim for payment has been denied, or that a claim your doctor sent in for payment was denied (see Medigap Protections, Situation #2 on page 44).

COBRA Coverage

COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that lets employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions. This is called "continuation coverage."

You may have this right if you lose your job, have your working hours reduced, or leave your job voluntarily. You may also have this right if you are covered under your spouse's plan and your spouse dies or you get divorced.

Words in purple are defined on pages 82-85.

COBRA generally lets you and your dependents keep the group coverage for 18 months (or up to 29 or 36 months in some cases). You may have to pay both your share and the employer's share of the premium. In some cases, you may also have to pay an administration fee.

COBRA Coverage (continued)

This law only applies to employers with 20 or more employees. Some state laws require employers with less than 20 employees to let you keep your group health coverage for a time. You can call your State Insurance Department (see pages 79-80) to find out if your state has this law or to get more information about group health coverage under COBRA. In most situations that give you COBRA rights, other than a divorce, you should get a notice from your benefits administrator. If you don't get a notice, or if you get divorced, you should call your benefits administrator as soon as possible.

Medicare and Continuation Coverage Under COBRA

If you already have continuation coverage under COBRA when you enroll in Medicare, your COBRA coverage may end. This is because the employer has the option of canceling the continuation coverage at this time. The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare.

For more information about COBRA, look at www.dol.gov on the web.

However, if you choose COBRA coverage after you enroll in Medicare, you can keep your continuation coverage. If you only have Medicare Part A when your group health plan coverage ends (based on **current or active** employment), you can enroll in Medicare Part B during a Special Enrollment Period without having to pay a higher Medicare Part B premium. This means you will have to sign up for Medicare Part B within eight months after your group health coverage ends or when the employment ends, whichever is first (see pages 7-8). If you don't sign up for Medicare Part B during the eight-month period, you will only be able to sign up during the General Enrollment Period (see page 7) and the cost of Medicare Part B may go up. Under COBRA, the employer group plan may require you to sign up for Medicare Part B.

Remember, once you're age 65 or older and enrolled in Medicare Part B, the Medigap open enrollment period starts and can't be changed (see page 18).

State law may give you the right to continue your coverage under COBRA beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law. For more information about your state's law, call your State Insurance Department (see pages 79-80).

Long-Term Care Insurance

This kind of insurance is sold by private insurance companies and usually covers medical care and non-medical care to help you with your personal care needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare does **not** pay for long-term care.

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see pages 79-80) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

For more information about the types of long-term care, get a free copy of *Choosing Long-Term Care: A Guide for People with Medicare* (CMS Pub. No. 02223). Look at www.medicare.gov on the web. Select "Publications." Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Veterans' Benefits

If you are a Veteran, call the U.S. Department of Veterans Affairs at 1-800-827-1000 for information about Veterans' benefits and services available in your area.

TRICARE for Life/Military Retiree Benefits

TRICARE for Life (TFL) provides expanded medical coverage for the following: Medicare-eligible uniformed services retirees, including retired National Guard members and reservists; Medicare-eligible family members and widow/widowers; and certain former spouses if they were eligible for TRICARE before age 65. You must have Medicare Part A and Part B to be eligible for TFL.

If eligible, you get all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits.

TRICARE for Life/Military Retiree Benefits (continued)

If you use a Medicare provider, Medicare will be the first payer for all Medicare-covered services, and TFL will be the second payer. TFL will pay all Medicare copayments and deductibles and cover most of the costs of certain care not covered by Medicare. For more information on TFL, call 1-888-DOD-LIFE (1-888-363-5433) or look at www.TRICARE.osd.mil on the web. Call 1-800-538-9552 for other military retiree eligibility and benefit questions.

Prescription Drug Assistance Programs

There are programs that may offer you discounts or free medication. For more information, look at www.medicare.gov on the web. Select "Prescription Drug Assistance Programs." If you don't have a computer, your local senior center or library may be able to help you get this information. Or, call 1-800-MEDICARE (1-800-633-4227) and ask for information about these programs. TTY users should call 1-877-486-2048.

Note: If you are considering signing up for your state's Prescription Drug Assistance Program and you haven't yet purchased a Medigap policy, get your Medigap policy **before** you apply for prescription drug assistance because after you get the prescription drug assistance you may not be able to purchase a Medigap policy.

Hospital Indemnity Insurance

This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. **It doesn't fill gaps in your Medicare coverage. Remember, Medicare and any Medigap policy you have will very likely cover costs from any hospital stay you have.** Therefore, you may not need this insurance.

Note: This kind of insurance isn't considered creditable coverage.

Specified Disease Insurance

This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. **It doesn't fill gaps in your Medicare coverage. Remember, Medicare and any Medigap policy you have will very likely cover costs from any specific disease you have.** Therefore, you may not need this insurance.

Note: This kind of insurance isn't considered creditable coverage.

Section 5: Coverage Charts

"I used the Preventive Service chart to see if diabetes services were covered."

Medicare Part A and Part B Coverage Charts

If you have general questions about Medicare Part A, call your Fiscal Intermediary. A Fiscal Intermediary is a private company that has a contract with Medicare to pay Medicare Part A and some Medicare Part B bills.

If you have general questions about Medicare Part B, call your Medicare carrier. A Medicare carrier is a private company that has a contract with Medicare to pay Medicare Part B bills.

If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC). A DMERC is a private company that has a contract with Medicare to pay bills for durable medical equipment.

To get these telephone numbers, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also get these telephone numbers at www.medicare.gov on the web. Select "Helpful Contacts."

Charts of Standardized Medigap Plans

For more information about these Medigap plans, call your State Insurance Department (see pages 79-80) or look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

COVERED SERVICES IN MEDICARE PART A

Medicare Part A (Hospital Insurance) Helps Pay For:	What YOU Pay in 2003* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in your room. It also doesn't include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period:** • A total of $840 for a hospital stay of 1-60 days. • $210 per day for days 61-90 of a hospital stay. • $420 per day for days 91-150 of a hospital stay. (See Lifetime Reserve Days on page 83.) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 3-day hospital stay).	**For each benefit period:** • Nothing for the first 20 days. • Up to $105 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary.
Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	• Nothing for home health care services. • 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary.
Hospice Care: For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in your home. However, short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest) are covered when needed.	• A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care. The amount you pay for respite care can change each year. Room and board are generally not payable by Medicare except in certain cases. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary.
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	• For the first three pints of blood, unless you or someone else donates blood to replace what you use.

* New Medicare Part A and Part B amounts will be available by January 1, 2004.

If you have general questions about Medicare Part A, call your Fiscal Intermediary. To get the telephone numbers for Fiscal Intermediaries or Regional Home Health Intermediaries, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

COVERED SERVICES IN MEDICARE PART B

Medicare Part B (Medical Insurance) Helps Pay For:	What YOU pay in 2003* in the Original Medicare Plan
Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, and outpatient physical and occupational therapy, including speech-language therapy.	• $100 deductible (once per calendar year). • 20% of the Medicare-approved amount after the deductible (if the doctor or provider accepts "assignment"). • 20% for all outpatient physical, occupational, and speech-language therapy services. • 50% for outpatient mental health care.
Clinical Laboratory Service: Blood tests, urinalysis, and more.	• Nothing for Medicare-approved services.
Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	• Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage call your Regional Home Health Intermediary.
Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.	• A coinsurance or copayment amount, which may vary according to the service.
Blood: Pints of blood you get as an outpatient or as part of a Part B covered service.	• For the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

* New Medicare Part A and Part B amounts will be available by January 1, 2004.

Note: Actual amounts you must pay may be higher if the doctor or supplier doesn't accept assignment **and you may have to pay the entire charge at the time of service**. Medicare will then send you its share of the charge. If you have general questions about Medicare Part B, call your Medicare carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC). For their telephone numbers, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

MEDICARE PART B PREVENTIVE SERVICES

Medicare Part B Covered Preventive Services	Who is covered...	What YOU pay in the Original Medicare Plan...
Bone Mass Measurements: Once every 24 months for qualified individuals and more frequently if medically necessary.	Discuss with your doctor to determine if you are a qualified individual.	20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every 12 months. • Flexible Sigmoidoscopy - Once every 48 months. • Colonoscopy - Once every 24 months if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. • Barium Enema - Doctor can use this instead of flexible sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older, except there is no minimum age for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount if the test is done in a hospital outpatient department.
Diabetes Services and Supplies: • Coverage for glucose monitors, test strips, and lancets. • Diabetes self-management training.	All people with Medicare who have diabetes (insulin users and non-users). Certain people with Medicare who are at risk for complications from diabetes. Your doctor or other health care provider must request these services.	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: • Once every 12 months. • Medicare also covers new digital technologies for mammogram screenings.	All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.	20% of the Medicare-approved amount with no Part B deductible.

MEDICARE PART B PREVENTIVE SERVICES (CONTINUED)

Medicare Part B Covered Preventive Services	Who is covered...	What YOU pay in the Original Medicare Plan...
Pap Test and Pelvic Examination (Includes a clinical breast exam): Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.	All women with Medicare.	Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older (coverage begins the day after your 50th birthday).	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Shots (vaccinations): • Flu Shot* - Once a year in the fall or winter. • Pneumococcal Pneumonia Shot - One shot may be all you will ever need. Ask your doctor. • Hepatitis B Shot	All people with Medicare. All people with Medicare. Certain people with Medicare at medium to high risk for Hepatitis B.	Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Glaucoma Screening: Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	People with Medicare who are at high risk for glaucoma, including people with diabetes, a family history of glaucoma, or African-Americans who are age 50 and older.	20% of the Medicare-approved amount after the yearly Part B deductible.

*The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year.

Chart Of Standardized Medigap Plans In Massachusetts

Basic Benefits included in all plans:

- **Inpatient Hospital Care**: Covers the Medicare Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **Medical Costs**: Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood**: Covers the first three pints of blood each year.

Medigap Benefits	Core Plan	Supplement 1 Plan	Supplement 2 Plan
Basic Benefits	✓	✓	✓
Medicare Part A: Inpatient Hospital Deductible		✓	✓
Medicare Part A: Skilled-Nursing Facility Coinsurance		✓	✓
Medicare Part B: Deductible		✓	✓
Foreign Travel Emergency		✓	✓
Inpatient Days in Mental Health Hospitals	60 days per calendar year	120 days per benefit year	120 days per benefit year
Prescription Drugs ($35 deductible each calendar quarter, then 100% coverage for generic drugs and 80% coverage for brand name drugs)			✓
State-Mandated Benefits (Annual Pap tests and mammograms. Check your plan for other state-mandated benefits.)	✓	✓	✓

For more information on these policies, call your State Insurance Department (see pages 79-80) or look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

Note: The checkmarks in this chart mean the benefit is covered under that plan.

Chart Of Standardized Medigap Plans In Minnesota

Basic Benefits included in all plans:

- **Inpatient Hospital Care**: Covers the Medicare Part A coinsurance.
- **Medical Costs**: Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood**: Covers the first three pints of blood each year.

Medigap Benefits	Basic Plan	Extended Basic Plan
Basic Benefits	✓	✓
Medicare Part A: Inpatient Hospital Deductible		✓
Medicare Part A: Skilled-Nursing Facility Coinsurance	✓	✓
Medicare Part B: Deductible		✓
Foreign Travel Emergency	80%	80%*
Outpatient Mental Health	50%	50%
Usual and Customary Fees		80%*
Preventive Care	✓	✓
Prescription Drugs		80%
At-home Recovery		✓
Physical Therapy	20%	20%
Coverage while in a Foreign Country		80%*
State-Mandated Benefits (Diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations.)	✓	✓

Optional Riders

- Medicare Part A: Inpatient Hospital Deductible
- Medicare Part B: Deductible
- Usual and Customary Fees
- Preventive Care
- Prescription Drugs
- At-home recovery

Insurance companies are allowed to offer six additional riders that can be added to a Basic plan. You may choose any one or all of the riders to design a Medigap plan that meets your needs.

*The policy pays 100% after you spend $1000 of out-of-pocket expenses for a calendar year.

Note: The checkmarks in this chart mean the benefit is covered under that plan.

Chart Of Standardized Medigap Plans In Wisconsin

Basic Benefits included in all plans:

- **Inpatient Hospital Care**: Covers the Medicare Part A coinsurance.
- **Medical Costs**: Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood**: Covers the first three pints of blood each year.

Medigap Benefits	Basic Plan
Basic Benefits	✓
Medicare Part A: Skilled-Nursing Facility Coinsurance	✓
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	40 visits in addition to those paid by Medicare
Medicare Part B: Coinsurance	✓
Outpatient Mental Health	✓
Prescription Drugs (after a deductible of $6,250, pays 80%)	✓

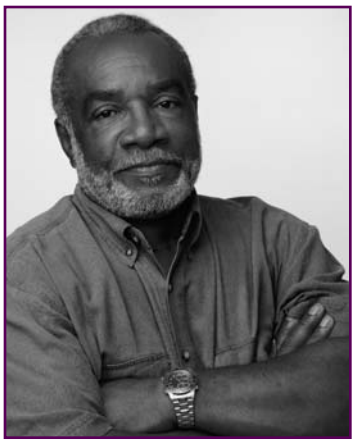
Optional Riders

- Medicare Part A Deductible
- Additional Home Health Care (365 visits including those paid by Medicare)
- Medicare Part B Deductible
- Medicare Part B Excess Charges
- Outpatient Prescription Drugs
- Foreign Travel

Insurance companies are allowed to offer additional riders to a Medigap plan.

Wisconsin also has many other state mandated benefits under the Medigap Basic Plan. For more information, call your State Insurance Department (see pages 79-80) or look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

Note: The checkmarks in this chart mean the benefit is covered under that plan.



"It is nice to know there is somewhere to go to get more information."

Section 6:
For More Information

"You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, including weekends. TTY users can call 1-877-486-2048."

"We visit www.medicare.gov for the latest Medicare information."

In this section, you will find telephone numbers to call for help with your questions. These telephone numbers were correct at the time of printing. Telephone numbers sometimes change. You can find the most up-to-date telephone numbers by looking at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Where To Get More Information

- Call your **State Health Insurance Assistance Program** for help with:
  - buying a Medigap policy, or long-term care insurance
  - dealing with payment denials or appeals
  - Medicare rights and protections
  - complaints about your care or treatment
  - choosing a Medicare health plan
  - questions about Medicare bills
- Call your **State Insurance Department** if you have questions about the Medigap policies sold in your area and any insurance related problems.

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

Section 7:
Words To Know

"I used this section to look up words I didn't know."

Assignment: In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Benefit Period: The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or Skilled Nursing Facility (SNF). The benefit period ends when you haven't received any hospital or skilled care (in a SNF) for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance: The percent of the Medicare-approved amount that you have to pay for items and services under Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment: In some Medicare health plans, the amount that you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible: The amount you must pay for Medicare covered services, before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

Durable Medical Equipment (DME): Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Durable Medical Equipment Regional Carrier (DMERC): A private company that contracts with Medicare to pay bills for durable medical equipment.

End-Stage Renal Disease (ESRD)*: Kidney failure that is severe enough to need lifetime dialysis or a kidney transplant.

Excess Charges: Any amount that the doctor or supplier charges you that is more than what Medicare will pay for (see "Medicare-Approved Amount").

Fiscal Intermediary: A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Guaranteed Issue Rights (also called "Medigap Protections"): Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

* This definition in whole or in part was used with permission from Walter Feldesman, Esq., "Dictionary of Eldercare Terminology 2000."

Guaranteed Renewable: A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you commit fraud or don't pay your premiums.

Home Health Care: Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.

Hospice Care: A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Lifetime Reserve Days: Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($420 in 2003).

Limiting Charge: The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Long-Term Care: A variety of services that help people with health or personal needs and activities of daily living over a long period of time. Long-term care can be provided at home; in the community; or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care.

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Underwriting: The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Medically Necessary: Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- are not mainly for the convenience of you or your doctor.

Medicare + Choice Plan: A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Medicare-Approved Amount: The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Carrier: A private company that contracts with Medicare to pay Part B bills.

Medicare Managed Care Plan: These are health care choices (like HMOs) in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Private Fee-for-Service Plan: A private insurance plan that accepts people with Medicare. You may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Medicare SELECT: A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medigap Policy: A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are ten standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Open Enrollment Period: A one-time-only six month period when you can buy any Medigap policy you want that is sold in your state. It starts when you sign up for Medicare Part B and you are age 65 or older. During this period, you cannot be denied coverage or charged more due to past or present health problems.

Original Medicare Plan: A fee-for-service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay any applicable deductible. Medicare then pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Pre-existing Condition: A health problem you had before the date that a new insurance policy starts.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

Programs of All-inclusive Care for the Elderly (PACE): PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must:

- Be 55 years old or older,
- Live in the service area of the PACE program,
- Be certified as eligible for nursing home care by the appropriate state agency, and
- Be able to live safely in the community.

The goal of PACE is to help people stay independent and living in their community as long as possible, while getting high quality care they need.

Skilled Nursing Care*: A level of care that must be given or supervised by Registered Nurses. All of your needs are taken care of with this type of service. Examples of skilled care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average non-medical person (or one's self) without the supervision of a Registered Nurse is not considered skilled care.

Skilled Nursing Facility: A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

State Health Insurance Assistance Program: A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

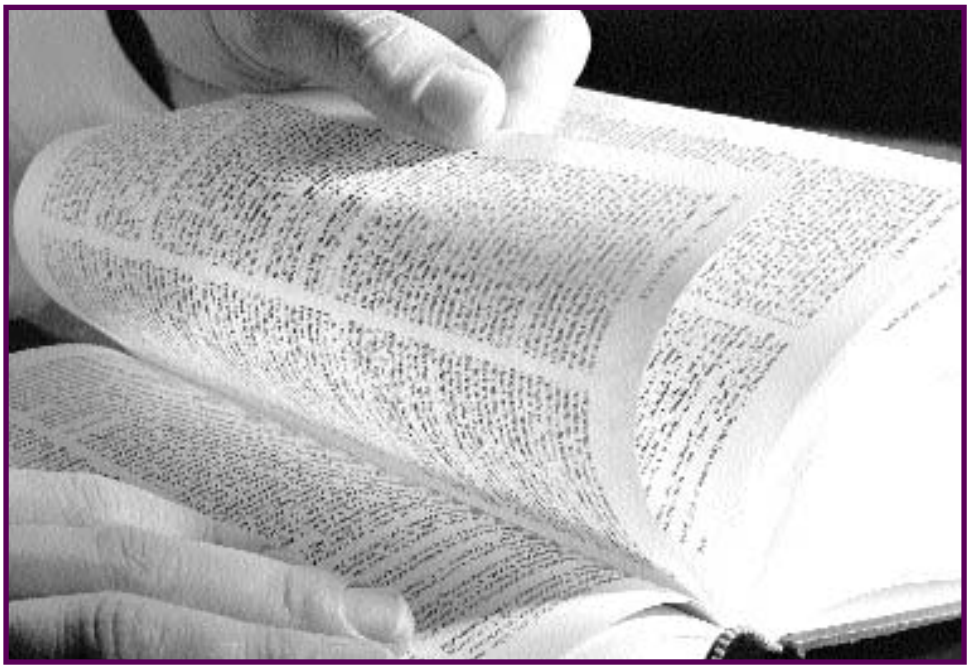
State Insurance Department: A state agency that regulates insurance and can provide information about Medigap policies and any insurance-related problem.

State Medical Assistance Office: A state agency that is in charge of the State's Medicaid program and can provide information about programs to help pay medical bills for people with low incomes. Also provides help with prescription drug coverage.

* This definition in whole or in part was used with permission from Walter Feldesman, Esq., "Dictionary of Eldercare Terminology 2000."

"I bought my Medigap policy during my Medigap open enrollment period."

Section 8: Index



This section is an alphabetical list of what is in this Guide.

M (continued)

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V

W

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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To get the *2003 Guide To Health Insurance For People With Medicare: Choosing a Medigap Policy* on Audiotape (English and Spanish), in Braille, Large Print (English), or Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

¿Necesita usted una copia de esta guía en Español? También está disponible en audiocassette. Llame gratis al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deberán llamar al 1-877-486-2048.